PERINATAL HEPATITIS B SURFACE ANTIGEN CASE REPORT

CASE NUMBER (FOR KDHE)	HAWK Number (If applicable)	DATE INITIATED (Mo/Da/Yr)

CLIENT INFORMATION

Last Name	Maiden Name	First Name	Middle Initial

Street Address

City	Zip Code	**COUNTY**

Occupation	Age (years)	Date of Birth (Mo/Da/Yr)

Race

____ African American ____Asian/Pacific Islander _____ (Ethnicity)

____Caucasian ____Alaskan/American Indian

____Other Hispanic Ethnicity Yes / No

LABORATORY INFORMATION

	Pos.	Neg.	Not Tested	Test Date (Mo/Da/Yr)
Hepatitis B surface antigen (HBsAg)	_____	_____	_____	_____/_____/_____
IgM Hepatitis B core (IgM anti-HBc)	_____	_____	_____	_____/_____/_____

CLINICAL DATA FOR HEPATITIS B

	(Mo/Da/Yr)		
Date of first symptom	_____/_____/_____	Was patient jaundiced?	Yes/ No
Date of diagnosis	_____/_____/_____	Was patient hospitalized for hepatitis B?	Yes/ No

If hospitalized for hepatitis B, then complete the following:

Hospital	Phone ( )
City	County

DELIVERY INFORMATION

Expected Delivery Date (Mo/Da/Yr)	Expected Delivery Hospital
_____/_____/_____	
City	County

Hospital Notified? Yes / No

PHYSICIAN INFROMATION

Physician's Name (OB/GYN)	Phone ( )
Physician's Name (Pediatrician)	Phone ( )

Case's Name (Last, First)_____

CONTACTS INFORMATION

ID #	Contact Name (Last, First)	Relationship to Case	Date of Birth (Mo/Da/Yr)	Date Screened (Mo/Da/Yr)	Test Results		Hepatitis B Vaccine		
					HBsAg	Anti-HBc	1 (Mo/Da/Yr)	2 (Mo/Da/Yr)	3 (Mo/Da/Yr)
	1				+ / --	+ / --			
	2				+ / --	+ / --			
	3				+ / --	+ / --			
	4				+ / --	+ / --			
	5				+ / --	+ / --			
	6				+ / --	+ / --			
	7				+ / --	+ / --			
	8				+ / --	+ / --			

INFANT INFORMATION

Infant's Name (Last, First)	Date of Birth (Mo/Da/Yr)	HBIG (Mo/Da/Yr)	Hepatitis B Vaccine			Date Screened* (Mo/Da/Yr)	Test Results		Revaccinate **
			1 (Mo/Da/Yr)	2 (Mo/Da/Yr)	3 (Mo/Da/Yr)		HBsAg	Anti-HBs	
							+ / --	+ / --	+ / --
							+ / --	+ / --	+ / --

* The screening on the infant should be done 3-9 months after completion of the hepatitis B series.

** Revaccinate only if both HBsAg and Anti-HBs are negative.

Completed by	Phone ( )	Agency

Please send completed forms to: Epidemiology Services Section, 1000SW Jackson, Suite 210, Topeka, KS 66612-1290

Phone 785/296-2951 Fax 785/291-3775